

PHYSICIAN AND OTHER HEALTH PROFESSIONAL PAYMENT SYSTEM

payment**basics**

Revised:
November 2018

Physician and other health professional services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 952,000 clinicians who bill Medicare, 62 percent are physicians. The remainder includes health professionals such as nurse practitioners, physician assistants, and physical therapists. These health professionals may bill Medicare independently (accounting for about 14 percent of physician fee schedule spending) or provide services under physician supervision.

Physician services are paid under Part B. Payments for these services (about \$70 billion in 2016) account for about 15 percent of Medicare fee-for-service (FFS) spending.

Medicare pays for physician and other health professional services based on a list of services and their payment rates, called the physician fee schedule. The Centers for Medicare & Medicaid Services (CMS) determines the payment rate for each service based on the clinician work required to provide the service, expenses related to maintaining a practice, and professional liability insurance (PLI) costs. The values given to these three components are adjusted to account for variations in the input prices in different markets, and then the total is multiplied by a standard dollar amount, called the fee schedule's conversion factor (\$36.00 in calendar year 2018), to arrive at the payment amount. Medicare's payment rates may be adjusted based on provider characteristics, additional geographic designations, and other factors. Medicare pays the provider the final amount, less

any beneficiary cost sharing. In 2016, Medicare paid for over one billion distinct services under the fee schedule. The conversion factor is updated according to a schedule set by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the prior sustainable growth rate formula, and the Bipartisan Budget Act of 2018.

Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is generally the individual service, such as an office visit or a diagnostic procedure. These range from narrow services (e.g., an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related pre-operative and post-operative visits. All services—surgical and non-surgical—are classified according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for over 7,000 distinct services.

Setting the payment rates

Under the fee schedule, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide clinician services: clinician work, practice expenses, and PLI. The RVUs for clinician work reflect the relative levels of time, effort, skill, and stress associated with providing each service. The RVUs for practice expense are based on the expenses clinicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI RVUs are based on the premiums clinicians pay for professional liability insurance, also known as medical malpractice insurance.

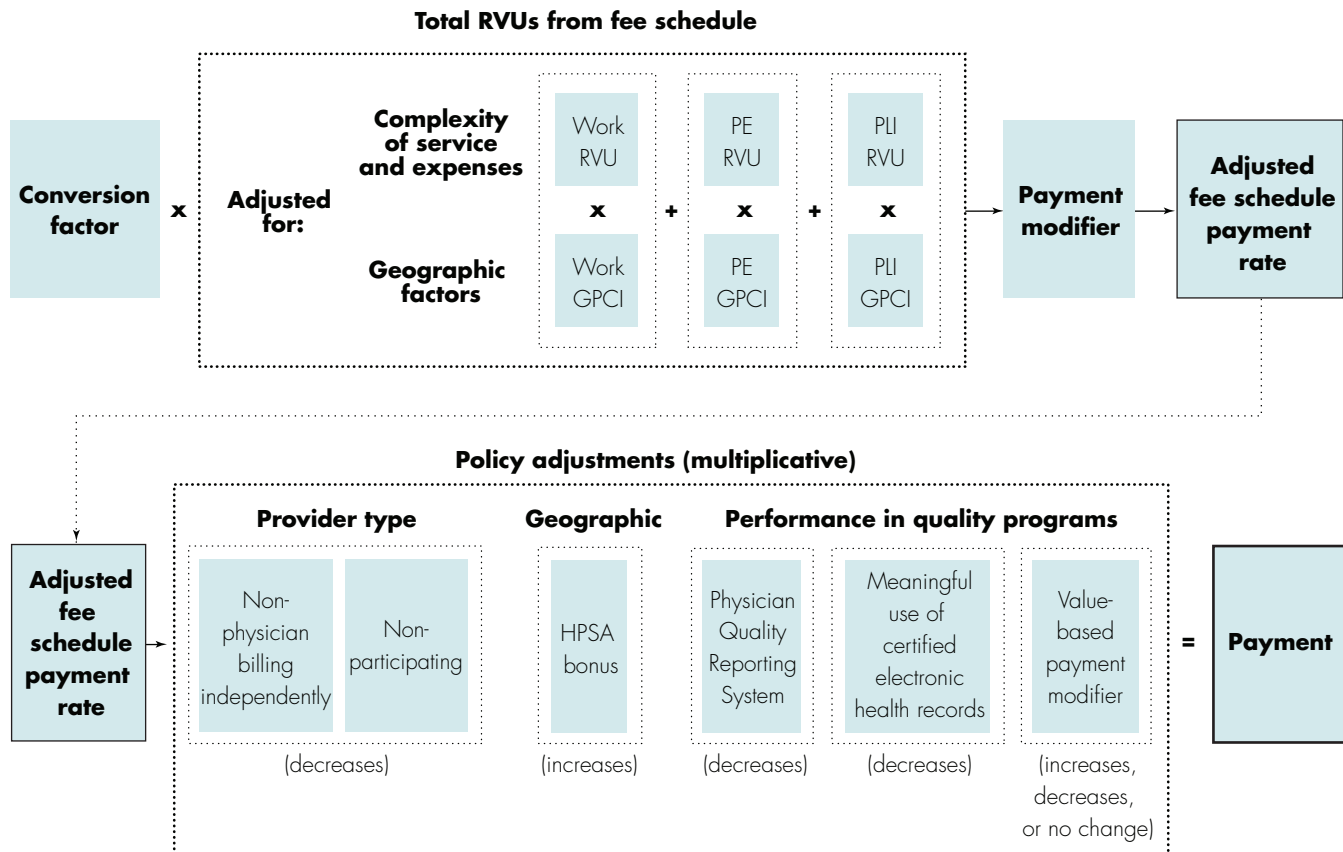
In calculating payment rates, each of the three RVUs is adjusted to reflect the price of inputs in the local market where the

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Figure 1 Physician and other health professional payment system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are often reduced when specified nonphysician practitioners bill Medicare separately, but not when services are provided “incident to” a physician’s service.

service is furnished. Separate geographic practice cost indexes (GPCIs) are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor (Figure 1). For most fee schedule services, Medicare pays the provider 80 percent of the fee schedule amount. The beneficiary is liable for the remaining 20 percent coinsurance.

Through payment modifiers, Medicare may adjust its payment for a service because of special circumstances. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the

primary surgeon. Other modifiers apply to multiple procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

There is a downward adjustment if services are furnished by certain nonphysician practitioners. For example, services billed separately and provided by advanced-practice nurses and physician assistants are paid at 85 percent of the full fee schedule amount. When nonphysician practitioners perform a service “incident to” a physician’s service or under direct physician supervision, they may not bill Medicare separately; Medicare pays the full fee schedule amount for the service as if the physician had personally furnished it.

Medicare also adjusts fee schedule payments downward when services are furnished by clinicians who are not in Medicare's participating provider program. Payment rates for services provided by nonparticipating providers are 95 percent of the full fee schedule amount.

Physicians may receive increases for services they provide in underserved areas. Under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

In 2019, MACRA's Merit-based Incentive Payment System (MIPS) will apply to certain clinicians. MIPS will make upward and downward adjustments to

payment based on clinician performance in four areas: quality, cost, promoting interoperability of electronic health information, and practice improvement.

Updating payments

CMS reviews the RVUs of new, revised, and some potentially misvalued services annually. HCPCS codes and the conversion factor are also updated annually. The update of RVUs includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In updating the RVUs, CMS receives advice from a group of physicians and other health professionals sponsored by the American Medical Association and specialty societies.

The annual updates to the conversion factor are set in statute. All providers will receive a yearly update of 0.5 percent from 2016 through 2018 and 0.25 percent in 2019. ■